



Integrated Wellness

CLIENT PROFILE

Name: _____ Birthdate: _____ Occupation _____

Address: _____ City: _____ Zip: _____

E-mail: _____ Home Phone: _____ Work Phone _____

Cell Phone: _____ Referred by: _____

THIS OFFICE DOES NOT RELEASE CLIENT INFORMATION TO THIRD PARTIES. IW SENDS EMAIL OR POST MAIL FOR SEASONAL OCCASIONS
Can we include you in our monthly email Newsletter? YES NO

GENERAL & MEDICAL INFORMATION

Have you ever received Chiropractic Care? YES NO How recently? _____

Have you ever received a professional Massage? YES NO How recently? _____

What type of massage do you prefer? LIGHT MEDIUM FIRM OTHER _____

Have you ever received a BodyTalk Session before? YES NO How recently? _____

Have you ever had an Acupuncture Treatment before? YES NO How recently? _____

Have you ever had Lymph Drainage before? YES NO How recently? _____

Have you ever had a BeautyTek treatment before? YES NO How recently? _____

Have you ever had a Breathwork and Pranic Healing YES NO How recently? _____

Do you suffer from stress? YES NO Do you have diabetes? YES NO

Do you have any blood pressure issues? YES NO Do you suffer from arthritis? YES NO

Do you experience frequent headaches? YES NO Are you wearing contact lenses? YES NO

Do you have any allergies? YES NO Are you taking any medications, YES NO
Supplements?

How often do you take antibiotics? _____ Do you have a pacemaker or other YES NO
implant?

Are you sensitive to touch or pressure in YES NO Do you have cardiac or YES NO
any area? circulation problems?

Have you had any lymph nodes YES NO Have you experienced any injuries, YES NO
removed or compromised? illness or surgeries in the past 2 yrs?

Are you pregnant? YES NO Are you breastfeeding? YES NO

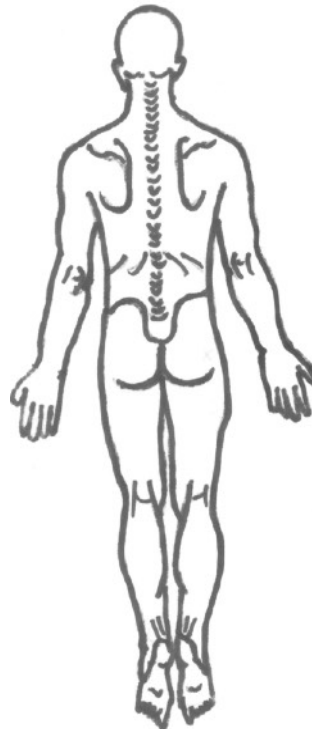
IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN BELOW:

PLEASE CONTINUE ON BACK PAGE



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Please mark on the Diagrams below the areas discomfort in your body:



Please list your health concerns and symptoms.

What are your MAIN/LONG TERM GOALS?

DISCLOSURES:

I understand that if medical examination and diagnosis is needed for my physical or mental condition, I will seek a medical specialist. I agree to keep the IW practitioners up to date during my session regarding my comfort. I also agree to update any changes in my IW general and medical record. I understand that my medical records will be kept confidential and will not be released without my written consent. I accept the responsibility of payment at the time of services rendered. By voluntarily signing this form, I hereby authorize IW practitioners to administer treatment. I will be advised of any risks and benefits of therapies that I will receive and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment. CLIENT INITIALS: _____

I acknowledge that any appointment cancelled without twenty- four hours notice will be charged to me. CLIENT INITIALS: _____

Emergency Contact Person _____ Emergency Phone _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

IW NOTES: _____